

2004 Health Insurance Market Report

Utah Insurance Department

October 5, 2004

The *2004 Health Insurance Market Report* was prepared by Jeffrey E. Hawley, Ph.D. of the Health Insurance Division for the Utah Insurance Commissioner pursuant to Utah Code Annotated (U.C.A.) § 31A-2-201(7).

For questions about this report contact:

Jeffrey E. Hawley, Ph.D.
Research Analyst
Health Insurance Division
Utah Insurance Department
3110 State Office Building
Salt Lake City, Utah 84114
801-538-9684
jhawley@utah.gov

Suzette Green-Wright, FMLI, AIRC, AIE, CPM
Director
Health Insurance Division
Utah Insurance Department
3110 State Office Building
Salt Lake City, Utah 84114
801-538-9674
sgreenwright@utah.gov

Table of Contents

List of Tables	ii
List of Figures	iii
Executive Summary	iv
Introduction.....	1
What is Health Insurance?	1
Estimate of Health Insurance Coverage in Utah.....	2
Utah’s Commercial Health Insurance Market	4
Commercial Health Insurance Market Overview	4
Commercial Health Insurance Market by Policy Type	6
Consumer Complaints Against Commercial Health Insurance Companies	7
Utah’s Comprehensive Health Insurance Market	11
Comprehensive Market by Domicile.....	11
Comprehensive Market by Plan Types.....	11
Comprehensive Market by Group Size.....	13
Comprehensive Market Trends.....	14
Summary	25
References.....	27
Appendix.....	28
List of Comprehensive Health Insurers.....	29
List of Health Insurance Mandates in Utah.....	31
Statutory Requirements and Methods Overview.....	33

List of Tables

Table 1. Estimate of Health Insurance Coverage for 2003	3
Table 2. Total Commercial Health Insurance Market by Insurer Type for 2003	5
Table 3. Total Commercial Health Insurance Market by Policy Type for 2003	6
Table 4. Estimated Number of Consumer Inquiries Handled by OCHA Staff.....	7
Table 5. Complaints Filed with OCHA by Type from 1999 to 2003	8
Table 6. Complaints Filed with OCHA by Reason from 1999 to 2003.....	9
Table 7. Complaint Ratios for Commercial Health Insurance Market from 1999 to 2003	9
Table 8. Commercial Health Insurance Companies with Consumer Complaints during 2003	10
Table 9. Total Comprehensive Market by Domicile for 2003.....	11
Table 10. Total Comprehensive Market by Plan Type for 2003	12
Table 11. Total Comprehensive Market by Group Size for 2003.....	13
Table 12. Changes in the Number of Comprehensive Insurers: 1999 - 2003	15
Table 13. Comprehensive Premium Compared to National Economic Trends: 1999 – 2003.....	16
Table 14. Comprehensive Losses Compared to National Health Care Spending: 1999 - 2003 ...	17
Table 15. Comparison of Utah Premium to National Averages: 1999 to 2003	17
Table 16. Changes in Comprehensive Premium and Per Capita Income: 1999 - 2003	19
Table 17. Changes in Comprehensive Membership by Group Size: 1999 – 2003	20
Table 18. Changes in Comprehensive Membership by Plan Type: 1999 – 2003	21
Table 19. Changes in Government Sponsored Health Benefit Plans: 1999 - 2003	22
Table 20. List of Comprehensive Insurers during 2003	29

List of Figures

Figure 1. Estimate of Health Insurance Coverage for 2003.....	2
Figure 2. Comprehensive Premium PMPM by Plan Type from 1999 to 2003.....	18
Figure 3. Comprehensive Premium PMPM by Group Size from 1999 to 2003.....	19
Figure 4. Income After Expenses For Managed Care Health Insurers from 1995 to 2003	24

Executive Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department.

Approximately 64 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 34 percent of Utah residents. The typical policy in this industry is an employee group policy with a managed care plan administered by a domestic health insurer.

A key function of the Utah Insurance Department is to assist consumers with questions and concerns they may have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the primary agency within the Utah Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the number of consumer complaints received by the Utah Insurance Department has declined every year since 1999. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last five years, there have been four significant trends in the comprehensive health insurance market that the Utah Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined steadily since 1999. This change is mainly due to a decrease in the number of small foreign health insurers participating in the comprehensive health insurance market. In contrast, there has been little or no change in the number of medium to large health insurers. Large domestic health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and competition for Utah's comprehensive health insurance market. This decline has impacted a small portion of the market and Utah's comprehensive health insurance market continues to be competitive.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from \$133 during 2002 to \$149 during 2003, an increase of 12.0 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that health insurers contract to pay for. For example, Utah's health insurers experienced a 13.6 percent increase in losses per member per month from 2002 to 2003. These pricing pressures are not unique to Utah and are being driven by national health care trends that are affecting most states in a similar way. Although these increases are difficult,

Utah's health insurance premiums appear to be lower than the national average. Based on the Kaiser/HRET national survey of employer benefits, the average cost for health insurance coverage for a single person was \$282 per month during 2003. Although this comparison does not control for differences in benefits, this national estimate is significantly more than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

The percentage of Utah residents covered by comprehensive health insurance declined steadily from 1999 to 2002. Based on the available information, this trend appears to be due to a shift by some larger employers from commercial insurance to employer sponsored self-funding arrangements, rather than an increase in the number of people in government programs or the uninsured. Thus, coverage shifted from one type of coverage to another, but there was no significant loss of coverage. As of 2003, this shift appears to have stopped and the number of residents covered by comprehensive health insurance appears to have stabilized. This suggests that consumers, despite rising premiums, are continuing to maintain health insurance coverage with commercial health insurers.

Over the last nine years the top insurers in the comprehensive health insurance industry have experienced an average loss of 0.08 percent. This trend has improved since 1999, however, with the core of the industry experiencing an average gain of 1.00 percent over the last five years. Although premiums have increased significantly during this period, the financial data from Utah's health insurers suggest that they are operating on very conservative financial margins and appear to be only charging enough premiums to cover their costs. Generally, Utah's health insurers are financially stable and are able to meet their financial obligations to Utah consumers.

Introduction

For most people, health insurance is essential for managing the costs of personal health care. Health insurance protects against the risk of financial loss that can occur from unexpected accidents and illnesses. It also provides a way for chronic health problems to be treated and managed in ways that many people could not otherwise afford. Because health insurance is so important to the citizens of Utah, it is in the interest of the State to monitor and maintain a stable health insurance industry.

An important purpose of the Insurance Department is to ensure that Utah has an adequate and healthy insurance market. The purpose of this report is to provide an annual evaluation of Utah's commercial health insurance market as required by Utah Code Annotated (U.C.A.) § 31A-2-201(7).

What is Health Insurance?

In general, health insurance transfers the risk of paying for personal health care from an individual to an entity that pools the risk. The individual shares in the management of his or her personal health care risk through the use of deductibles, coinsurance, and the health benefits provided by insurance. Individuals obtain their health benefits from one or more of three health insurance sources: government sponsored health benefit plans, employer sponsored self-funded health benefit plans, and commercial insurance health benefit plans. The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits.

Government sponsored health benefit plans are government programs that provide health insurance benefits. These programs may be funded entirely by government funds or by a combination of government funds and premiums paid by the covered individuals enrolled in the program. The risk of financial loss is borne by the government. These programs may provide comprehensive major medical health insurance benefits (such as Medicaid and Medicare), limited primary health insurance benefits (such as county health clinics), or limited specialized health insurance benefits (such as Wee Care).

Employer sponsored self-funded health benefit plans are plans sponsored by an employer to provide health insurance benefits to the employer's employees. These plans may be funded entirely by the employer or by a combination of employer funds and amounts withheld from covered employees' wages. The risk of financial loss is borne by the employer. These plans usually provide comprehensive major medical health insurance benefits, and may provide benefits only to the employee or to the employee and the employee's dependents.

Commercial insurance health benefit plans are plans marketed by an insurance company to provide health insurance benefits to insured persons. These plans are funded by the premiums collected from insured employers and individuals. The risk of financial loss is borne by the insurance company. Commercial insurance benefit plans can be issued as fee for service plans (such as Western Mutual Insurance Company), nonprofit health service plans (such as Regence Blue Cross Blue Shield of Utah), health maintenance organizations (such as IHC Health Plans),

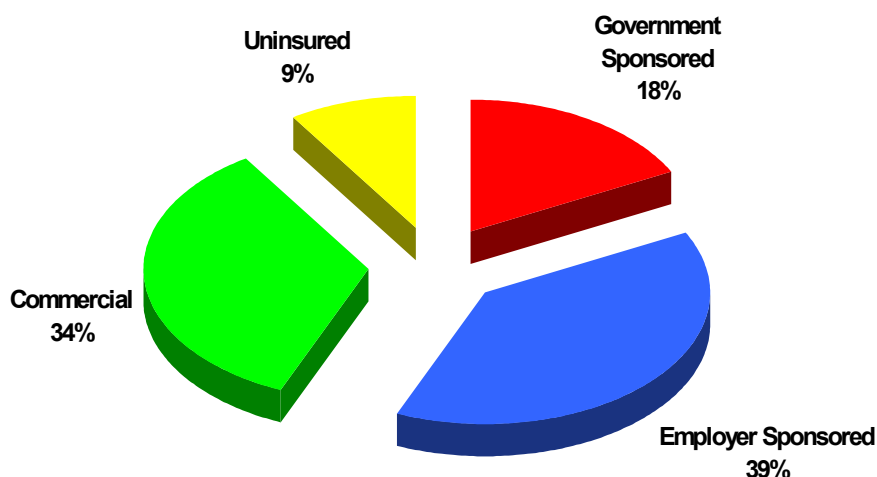
and limited health plans (such as Delta Dental Care of Utah). The health insurance benefits provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits such as dental, vision, or specified disease.

Each of these three sources of health insurance is regulated by a different set of laws and government agencies. Government sponsored health insurance is regulated by Federal regulatory agencies like the Centers for Medicare and Medicaid Services (CMS). Employer sponsored self-funded health insurance is regulated for the most part under the Federal ERISA statute through the Department of Labor (DOL), the Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS). Commercial health insurance is governed by state and federal law and is regulated by state insurance departments. This report focuses on the commercial health insurance market regulated by the Utah Insurance Department.

Estimate of Health Insurance Coverage in Utah

As mentioned previously, health insurance comes from three sources: government, employers, and commercial insurers. The Utah Insurance Department has attempted to estimate how much of the state is insured by each source of health insurance. The estimate is for comprehensive health insurance coverage only (also known as major medical). A general overview of the department's estimate is shown below in Figure 1 (see Table 1 for details).

Figure 1. Estimate of Health Insurance Coverage for 2003



Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2003 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. The estimate assumes that the total employer based group coverage (commercial and self-funded) will be close to 71 percent, as estimated in the 2003 Utah Health Status Survey.

Caution should be used interpreting these results, however, as multiple data sources with differing methods were required to create this estimate. For example, membership data for government sponsored health benefit plans was obtained from the Utah Department of Health and the Centers for Medicare and Medicaid Services (CMS). Membership data for commercial health insurance was obtained from the Utah Accident & Health Survey, a survey conducted annually by the Utah Insurance Department.

The estimate for the uninsured was obtained from the Utah Health Status Survey. This survey is believed to be a more accurate estimate of the uninsured in Utah than the Census Bureau estimates developed from the Current Population Survey. The Current Population Survey tends to overestimate the number of uninsured in small states like Utah. The Utah Health Status Survey has a larger sample size and is a better measure of the uninsured for Utah.

Finally, membership in employer sponsored self-funded benefit plans was estimated using the best information available to the Insurance Department. Currently, there is no single source of self-funded membership data for Utah. As a result, a “best guess” estimate was created using a combination of membership data obtained from large self-funded employers, commercial health insurers who administer self-funded health benefit plans, and the Utah Health Status Survey. The result is imperfect, but it does provide an estimate of the self-funded population.

Given these limitations, the Utah Insurance Department estimates that eighteen percent of Utah residents were covered by government plans, thirty-nine percent were covered by employer sponsored self-funded plans, thirty-four percent were covered by commercial health insurance, and nine percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2003

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans (Regulated by CMS)	420,095	17.61%
Medicare	220,221	9.23%
Medicaid	156,031	6.54%
Children's Health Insurance Program (CHIP)	23,761	1.00%
Primary Care Network (PCN)	17,228	0.72%
Utah Comprehensive Health Insurance Pool (HIPUtah)	2,854	0.12%
Employer Sponsored Self-Funded Plans (Regulated by Federal Gov.)	925,930	38.82%
Plans Administered by Commercial Insurers	365,174	15.31%
Public Employee Health Program (PEHP)	174,080	7.30%
Federal Employee Health Benefit Plan (FEHBP)	72,525	3.04%
Other Known Self-Funded Plans	44,506	1.87%
Other Self-Funded Plans (Estimated)	269,645	11.30%
Commercial Health Insurance Plans (Regulated by State Gov.)	822,265	34.47%
Group	690,714	28.96%
Individual	131,551	5.51%
Uninsured	217,068	9.10%
Total	2,385,358	100.00%

Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2003 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. The estimate assumes that the total employer based group coverage (commercial and self-funded) will be close to 71 percent, as estimated in the 2003 Utah Health Status Survey.

Utah's Commercial Health Insurance Market

Commercial insurance carriers are companies in the business of managing risk. They accept the risk of loss to individuals or organizations in exchange for a premium. In doing so, the risk of loss is shared (or pooled) so that any one individual does not bear all the risk of loss.

Insurance companies report financial data to the Utah Insurance Department and the National Association of Insurance Commissioners (NAIC) on the health insurance business written in Utah. Health insurance premium data includes premiums from individual and group policyholders and from government sponsored programs such as Medicare and Medicaid. The premium reported does not include fees paid to insurers for administration of employer sponsored self-funded health benefit plans.

One measure of an insurer's financial health is the ratio of incurred losses to premiums earned. This ratio is called a loss ratio. A ratio of less than 100 indicates that an insurance company received more premium income than it paid out in claims. A ratio of more than 100 indicates that a company paid more in claims than it received in premium income. While the benchmarks vary depending on the type of insurance, health insurers generally try to maintain a loss ratio of less than 85 (85 cents of losses for every dollar of premium). If the loss ratio increases much beyond 85, an insurer may have more expenses than income and suffer a financial loss.

Commercial Health Insurance Market Overview

Among commercial insurers there is a broad universe of "health insurance" products. Commercial health insurance may include comprehensive health insurance, as well as insurance products that cover a specialized category such as long-term care, dental, vision, disability, accident, specified disease, or as a supplement to other kinds of health benefit plans.

There were 1,427 licensed insurers registered with the Insurance Department at the end of 2003. Of these, three hundred and seventy insurers reported health insurance business in Utah on their 2003 Annual Financial Statements. These insurers represent all of the health insurance sold in Utah. Each insurer reported direct premium and losses in Utah, as well as total revenue and net income for their company.

Table 2 summarizes some of the characteristics of Utah's health insurance market that can be obtained from annual financial statements. Utah's health insurance market is highly concentrated among eight health insurers, who represent approximately 76 percent of the market. As a group, Utah's accident & health insurers had a loss ratio of 84 and net income of 4.33 percent (see Table 2). While looking at the loss ratio does give an accurate view of Utah's total market, net income (at this level) does not. In this case, net income is not a good measure of the financial health of Utah's market as less than one percent of total revenues reported were in Utah. A more accurate view is obtained by looking at state of domicile.

Domestic companies have a home office in Utah. Foreign insurers have a home office in another state. Nearly 80 percent of Utah's health insurance market is domestic. These 22 domestic insurers are much more representative of the Utah market as more than 70 percent of their total revenue comes from Utah business. Thus, their loss ratios and net income are a much more accurate measure of the Utah market. As a group, domestic insurers had a loss ratio of 85 and net income of 0.68 percent. Eight health insurers represent approximately 95 percent of Utah's domestic market. The remaining five percent of the market consists of life insurers and limited health plans.

There are 348 foreign insurers in Utah's commercial health insurance market, most of which are life insurers. Only 20 percent are foreign insurers. Foreign insurers had a loss ratio of 76 for Utah business. Net income was 4.33 percent, but a negligible amount of total revenue (less than 0.01 percent) was from Utah business and is, therefore, not representative of Utah (see Table 2). Overall, foreign insurers have a small presence in Utah's health insurance market.

Table 2. Total Commercial Health Insurance Market by Insurer Type for 2003

Insurer Type	Company Count	Utah Operations			National Operations	
		Direct Earned Premium	Market Share	Loss Ratio	Total Revenue	Net Income (% Rev)
Domestic Insurers						
Health	8	\$1,654,969,674	75.88%	84.93	\$1,648,818,450	-0.09%
Life	9	\$83,460,863	3.83%	91.65	\$813,244,268	2.26%
Limited Health Plan	5	\$3,394,338	0.16%	69.99	\$3,408,906	0.12%
Total Domestic	22	\$1,741,824,875	79.87%	85.22	\$2,465,741,624	0.68%
Foreign Insurers						
Fraternal	10	\$555,319	0.03%	31.40	\$7,946,821,262	-0.27%
Life	290	\$381,919,105	17.51%	75.79	\$492,319,967,164	4.60%
Property & Casualty	48	\$56,597,602	2.60%	85.39	\$122,412,206,333	3.60%
Total Foreign	348	\$439,072,026	20.13%	76.97	\$622,678,994,759	4.34%
Utah Insurers						
Fraternal	10	\$555,319	0.03%	31.40	\$7,946,821,262	-0.27%
Health	8	\$1,654,969,674	75.88%	84.93	\$1,648,818,450	-0.09%
Life	299	\$465,379,968	21.34%	78.63	\$493,133,211,432	4.60%
Limited Health Plan	5	\$3,394,338	0.16%	69.99	\$3,408,906	0.12%
Property & Casualty	48	\$56,597,602	2.60%	85.39	\$122,412,206,333	3.60%
Total Utah	370	\$2,180,896,901	100.00%	83.56	\$625,144,466,383	4.33%

Data Sources: NAIC Financial Database and Utah Accident & Health Survey

Note: The total direct earned premium and total revenue for health insurers is slightly higher than is reported on the 2003 NAIC Financial Statement. This difference is due to an accounting adjustment made by the author. This adjustment was necessary because of a recent change in accounting practices for Administrative Service Only (ASO) business among health insurers. The adjustment does not change the meaning of the data and simply presents the income data as if all the health insurers were using the same accounting method.

Commercial Health Insurance Market by Policy Type

Financial statement data is designed to measure the financial solvency of commercial insurers. As such, it is not designed to provide detailed information on a particular type of insurance. To compensate for this, Utah's commercial health insurers are required to participate in the Utah Accident & Health Survey. This survey collects data about the various types of health insurance in greater detail than the annual statement. Data was collected from 370 commercial health insurers who reported accident & health premium in Utah for 2003.

The top three policy types by market share were comprehensive health insurance (64 percent), the Federal Employee Health Benefit Plan (FEHBP) (10 percent), and Medicare Supplement (5 percent) (see Table 3). The results of the survey differ slightly from the total accident & health reported on the 2003 annual statement. However, the difference is small. The net difference in total reported direct earned premium is less than 0.02 percent.

Table 3. Total Commercial Health Insurance Market by Policy Type for 2003

Policy Type	Company Count	Member Count^b	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	76	822,265	\$1,405,078,420	64.42%	84.06
Medical Only	44	5,850	\$3,095,419	0.14%	53.27
Medicare Supplement	80	73,152	\$114,639,614	5.26%	72.49
Dental	65	295,018	\$91,023,487	4.17%	100.79
Vision	29	112,212	\$8,090,355	0.37%	81.11
FEHBP	6	72,529	\$219,718,343	10.07%	91.49
Medicare ^a	3	262	\$170,240	0.01%	40.33
Medicaid	4	45,340	\$90,373,688	4.14%	85.93
Stop Loss	45	180,583	\$68,994,146	3.16%	65.57
Disability Income	183	345,572	\$78,311,966	3.59%	105.17
Long Term Care	79	25,679	\$25,360,110	1.16%	35.51
Credit A&H	55	265,656	\$14,884,196	0.68%	25.79
Other	227	-	\$61,472,153	2.82%	63.21
Total	370	-	\$2,181,212,137	100.00%	83.54

Data Source: Utah Accident & Health Survey

^a Two companies reported claim activity for Medicare. This is probably due to discontinued policies in runoff and does not represent any active Medicare business in the state. Thus, the membership and premium reported here represent one company.

^b A total is not reported for the column "Member Count" and for "Other". A sum total of the membership counts of all types of health insurance would overestimate the actual number of persons covered by commercial health insurance due to uncontrolled double counting of members.

Consumer Complaints Against Commercial Health Insurance Companies

A key function of the Utah Insurance Department is to assist consumers with questions and concerns that they may have about commercial health insurance coverage. The primary agency within the Utah Insurance Department that assists consumers with health insurance issues is the Office of Consumer Health Assistance (OCHA).

The Office of Consumer Health Assistance seeks to provide a variety of needed services to health care consumers and policymakers, including (but not limited to):

- Assisting consumers in understanding their contractual rights and responsibilities, statutory protections and available remedies under their health program
- Providing health care consumer education (producing, collecting, disseminating educational materials; conducting outreach programs and other educational activities)
- Investigating and resolving complaints
- Assistance to those having difficulty accessing their health care plan because of language, disability, age, or ethnicity
- Providing information and referral to these persons as well as help with initiating a grievance process
- Analyzing and monitoring federal and state statutes, rules, and regulations that apply to health care consumers

On average, the Office of Consumer Health Assistance handles more than 10,000 consumer inquiries each year (see Table 4). These inquiries range from simple questions about how to obtain health insurance coverage to complaints against a particular health insurance company.

Table 4. Estimated Number of Consumer Inquiries Handled by OCHA Staff

Consumer Inquiries	1999*	2000	2001	2002	2003
Telephone (in/out)	6,234	14,108	14,886	11,535	10,054
Walk-in	38	67	27	36	75
Other (in/out)	172	63	516	682	999
Total Inquires	6,444	14,238	15,429	12,253	11,128

Data Source: Utah Insurance Department

* The Office of Consumer Health Assistance (OCHA) was created July 1, 1999. Data reported here is only for consumer inquiries received after the creation of OCHA.

When a consumer inquiry involves a possible violation of the Utah Insurance Code by a commercial health insurance company, the Office of Health Assistance encourages consumers to file a written complaint. Once a written complaint is received, the Office of Consumer Health Assistance conducts an investigation and seeks to resolve the consumer complaint. The Office of Consumer Health Assistance tracks all written complaints made against commercial health insurers. These complaints are classified into three types: justified, question of fact, and unjustified (see Table 5).

Justified complaints. Justified complaints are those where the Insurance Department rules in favor of the consumer making the complaint. The Insurance Department determines that the complaint is warranted under the law and resolves the complaint by requiring the commercial health insurer to act to correct the problem.

Question of fact complaints. Question of Fact complaints are those where the complaint appears to be legitimate, but the Insurance Department was unable to make a ruling, either because there are unresolved questions about the facts of the case or because the department does not have the legal authority to do so. These complaints usually must be resolved by arbitration, mediation, or litigation.

Unjustified complaints. Unjustified complaints are those where the Insurance Department rules in favor of the commercial insurer as the insurer was judged to be acting within the bounds of the law. The department educates consumers as to their rights under the law and how health insurance contracts work.

As shown in Table 5, the number of justified and unjustified complaints has remained fairly constant since 1999. However, the number of question of fact complaints has gone down significantly. This trend is due to an active effort by the Office of Consumer Health Assistance staff to resolve these complaints before they rise to the level of a written consumer complaint. Also, most health insurers have been actively working to resolve concerns with consumers before they rise to the level of a consumer complaint. This is a positive trend for the industry.

Table 5. Complaints Filed with OCHA by Type from 1999 to 2003

Year	Total		Justified		Question of Fact		Unjustified	
	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	70	21.5%	179	54.9%	77	23.6%
2000	244	100.0%	70	28.7%	123	50.4%	51	20.9%
2001	258	100.0%	127	49.3%	36	14.0%	95	36.8%
2002	174	100.0%	73	42.0%	27	15.5%	74	42.5%
2003	120	100.0%	54	45.0%	7	5.8%	59	49.2%
Average	224	100.0%	79	35.1%	74	33.2%	71	31.7%

Data Source: Utah Insurance Department

In addition to tracking the number of written complaints and how they are resolved, the Utah Insurance Department also tracks the reason for the complaint. As shown in Table 6, approximately two-thirds of all consumer complaints are due to claim handling issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason from 1999 to 2003

Year	Total*		Claim Handling		Policyholder Services		Marketing & Sales	
	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	218	66.9%	80	24.5%	28	8.6%
2000	244	100.0%	163	66.8%	31	12.7%	50	20.5%
2001	265	100.0%	174	65.7%	74	27.9%	17	6.4%
2002	175	100.0%	125	71.4%	44	25.1%	6	3.4%
2003	120	100.0%	77	64.2%	39	32.5%	4	3.3%
Average	226	100.0%	151	67.0%	265	23.7%	21	9.3%

Data Source: Utah Insurance Department

* A complaint may have more than one reason code, so totals may be slightly higher than the actual number of complaints.

Complaint ratios. Another measure of complaint activity is the complaint ratio. A complaint ratio is a measure of how many consumer complaints were received compared to the amount of business a commercial health insurer did in the state. Table 7 reports the average complaint ratios for the commercial health insurance market from 1999 to 2003 (see Table 7). Each complaint ratio reports the number of complaints per \$1,000,000 in total direct earned premium. For example, a ratio of 1 means the insurer had 1 complaint for every \$1,000,000 in premium.

Table 7. Complaint Ratios for Commercial Health Insurance Market from 1999 to 2003

Year	Direct Earned Premium	Total		Justified		Question of Fact		Unjustified	
		Count	Ratio	Count	Ratio	Count	Ratio	Count	Ratio
1999	\$1,887,679,133	326	0.17	70	0.04	179	0.09	77	0.04
2000	\$2,053,470,759	244	0.12	70	0.03	123	0.06	51	0.02
2001	\$2,171,040,169	258	0.12	127	0.06	36	0.02	95	0.04
2002	\$2,181,743,936	174	0.08	73	0.03	27	0.01	74	0.03
2003	\$2,180,896,901	120	0.06	54	0.02	7	< 0.01	59	0.03
Average	\$2,094,966,180	224	0.11	79	0.04	74	0.04	71	0.03

Data Sources: NAIC Financial Database and Utah Insurance Department

As discussed previously, the Utah Insurance Department has seen a decline in the total number of complaints from 1999 to 2003. This is primarily due to a decline in the number of question of fact complaints as part of a concerted effort by the Office of Consumer Health Assistance staff and the Utah health insurance industry to reduce the number of these kinds of complaints.

However, the number of justified and unjustified complaints has remained fairly constant, and this should be taken into account when looking at the pattern of the complaint ratios. As Table 7 shows, the average complaint ratio for the commercial market is about 0.11 for all complaints, and about 0.04 for each complaint type. Using this average as a benchmark, the complaint ratios for 2003 are significantly lower than their five-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2003. The averages in Table 7 can be used to give perspective to these individual ratios. For example, a commercial health insurer with a justified complaint ratio of greater than 0.04 has a higher than average number of complaints, while a ratio of less than 0.04 means a lower than average number of complaints. It is also important to remember that a complaint ratio is only one aspect of evaluating a commercial health insurance company (see Table 8).

Table 8. Commercial Health Insurance Companies with Consumer Complaints during 2003

Company Name	Direct Earned Premium	Market Share	Total ^a		Justified		Question Of Fact	
			Count	Ratio	Count	Ratio	Count	Ratio
Aetna Life Ins Co	\$16,121,395	0.74%	1	0.06	-	-	-	-
Altius Health Plans Inc	\$282,740,605	12.96%	13	0.05	7	0.02	-	-
American Family Life Asr Co Columbus	\$15,662,823	0.72%	4	0.26	2	0.13	-	-
American Heritage Life Ins Co	\$1,363,404	0.06%	1	0.73	-	-	-	-
American Natl Ins Co	\$1,155,992	0.05%	1	0.87	-	-	-	-
American Natl Life Ins Co Of TX	\$1,127,258	0.05%	1	0.89	1	0.89	-	-
Bankers Life & Cas Co	\$4,689,772	0.22%	1	0.21	1	0.21	-	-
Clarendon Natl Ins Co	\$3,054,996	0.14%	1	0.33	1	0.33	-	-
Connecticut General Life Ins Co	\$3,889,479	0.18%	2	0.51	2	0.51	-	-
Conseco Health Ins Co	\$3,947,331	0.18%	2	0.51	1	0.25	-	-
Continental Cas Co	\$3,223,001	0.15%	3	0.93	-	0.00	-	-
Educators Mut Ins Assoc	\$42,686,186	1.96%	1	0.02	1	0.02	-	-
Fortis Ins Co	\$1,616,350	0.07%	2	1.24	1	0.62	-	-
Guardian Life Ins Co Of Amer	\$1,576,380	0.07%	1	0.63	1	0.63	-	-
IHC Health Plans Inc	\$600,943,609	27.55%	11	0.02	3	< 0.01	-	-
Mega Life & Health Ins Co The	\$7,218,733	0.33%	3	0.42	1	0.14	-	-
Metropolitan Life Ins Co	\$19,053,519	0.87%	1	0.05	-	-	-	-
Mid West Natl Life Ins Co Of TN	\$3,835,310	0.18%	4	1.04	2	0.52	-	-
National Foundation Life Ins Co	\$1,773,973	0.08%	3	1.69	2	1.13	-	-
Penn Treaty Network Amer Ins Co	\$1,057,950	0.05%	1	0.95	-	-	-	-
Prudential Ins Co Of Amer	\$3,695,049	0.17%	1	0.27	-	-	-	-
Pyramid Life Ins Co	\$1,049,385	0.05%	1	0.95	-	-	-	-
Regence BCBS of UT	\$560,697,870	25.71%	19	0.03	6	0.01	1	< 0.01
Standard Ins Co	\$6,667,843	0.31%	1	0.15	-	-	-	-
Sterling Life Ins Co	\$4,259,276	0.20%	1	0.23	1	0.23	-	-
Teachers Ins & Ann Assoc Of Amer	\$3,753,435	0.17%	1	0.27	1	0.27	-	-
United American Ins Co	\$7,117,404	0.33%	9	1.26	6	0.84	3	0.42
United Healthcare Ins Co	\$78,286,943	3.59%	5	0.06	1	0.01	1	0.01
United Healthcare Of UT Inc	\$78,330,429	3.59%	11	0.14	7	0.09	-	-
United WI Life Ins Co	\$6,237,336	0.29%	1	0.16	1	0.16	-	-
Unum Life Ins Co Of Amer	\$9,758,123	0.45%	2	0.20	2	0.20	-	-
Western Mut Ins	\$6,582,718	0.30%	2	0.30	-	-	1	0.15
Top 32 Companies with complaints ^b	\$1,783,173,877	81.76%	111	0.06	51	0.03	6	< 0.01
Remaining 8 companies with complaints ^c	\$4,111,774	0.19%	9	2.19	3	0.73	1	0.24
Companies without complaints	\$393,611,250	18.05%	-	-	-	-	-	-
Total Commercial Market	\$2,180,896,901	100.00%	120	0.06	54	0.02	7	< 0.01

Data Sources: NAIC Financial Database, Utah Accident & Health Survey, and Utah Insurance Department.

^a Total complaints includes Justified, Question of Fact, and Unjustified. Unjustified are not shown separately.

^b Describes all companies with at least \$1,000,000 in total direct earned premium.

^c Separate complaint ratios were not calculated for companies with less than \$1,000,000 in total direct earned premium because it produces distorted ratios that cannot be directly compared to other companies.

Utah's Comprehensive Health Insurance Market

Comprehensive health insurance makes up 64 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 34 percent of Utah residents (see Table 1). It is the only type of major medical health benefit plan directly regulated by the Utah Insurance Department. The following analysis of the comprehensive market examines various aspects of the market including state of domicile, health benefit plan type, group size, and market trends.

Comprehensive Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Domestic insurers generally have a larger presence in their state of domicile than foreign insurers. Their local status may assist them in negotiating more favorable provider contracts and creating larger provider networks than foreign insurers.

Approximately 93 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among 10 insurers. Sixty-six foreign insurers represent the remaining market share. Domestic insurers reported a lower premium per member per month (\$147) than foreign insurers (\$171). Loss ratios were lower for foreign insurers (see Table 9).

Table 9. Total Comprehensive Market by Domicile for 2003

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM*
Domestic	10	770,131	\$1,306,148,102	92.96%	84.63	\$147
Foreign	66	52,134	\$98,930,318	7.04%	76.46	\$171
Total	76	822,265	\$1,405,078,420	100.00%	84.06	\$149

Data Source: Utah Accident & Health Survey

* Direct earned premium per member per month

Comprehensive Market by Plan Types

Comprehensive health insurance plans can generally be classified into four types: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Point of Service Plans (POS), and Fee for Service Plans (FFS). These plan types differ in the amount of managed care used to maintain quality and manage the cost of health care services. The term "managed care" refers to the methods many third-party payers use to ensure quality care (such as disease management programs) and to reduce utilization and cost of health care services (such as pharmacy benefit managers and medical review boards). HMO plans generally have the most management of care; whereas FFS plans generally have the least. All of these plans provide comprehensive health services consistent with the basic benefit plan required by the Utah Insurance Code.

A Health Maintenance Organization (HMO) refers to a “prepaid” health insurance plan where policyholders pay a fixed monthly fee for comprehensive major medical coverage. An HMO plan usually covers more preventative care services than other kinds of plans, but also manages care more than other kinds of plans. Services are provided through a network of health care providers that have negotiated a fee schedule with the HMO. Members enrolled in the plan generally pay a fixed co-pay for physician visits and drugs. Services are usually not available outside the provider network.

A Preferred Provider Organization (PPO) refers to a health plan that contracts with health care providers for a reduced fee. Providers under contract are referred to as preferred providers. Members have financial incentives to use the preferred providers. Members can use non-preferred providers, but they must pay significantly higher co-payments.

A Point of Service plan (POS) is a hybrid of HMO plans and PPO plans. Generally, a POS plan combines an HMO or PPO arrangement with a traditional fee for service plan. Members are encouraged to use the POS network providers, but may also use non-network providers under a more traditional fee for service arrangement. Costs are generally much higher for out of network providers. POS plans generally manage care more than a PPO, but less than an HMO.

A Fee for Service plan (FFS) refers to a traditional indemnity plan. Health care providers are usually reimbursed at a fixed percent of billed charges. Members can use any covered health care providers they choose, but they also pay a larger portion of the cost for services.

HMO, PPO, and POS plans are considered managed care plans. FFS plans typically do not involve any form of managed care. Nearly 90 percent of Utah’s comprehensive health market involves some type of managed care, with more than 49 percent of the comprehensive health market in an HMO type plan.

Premium per member per month was significantly higher for PPO plans compared to the other plan types. POS plans and HMO plans had lower premiums than PPO and FFS plans. This is consistent with the higher levels of managed care utilized by POS and HMO plans (see Table 10).

Table 10. Total Comprehensive Market by Plan Type for 2003

Plan Type	Company Count*	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM**
Health Maintenance Organization	6	416,952	\$692,821,458	49.31%	85.84	\$143
Preferred Provider Organization	33	142,120	\$290,042,152	20.64%	78.17	\$174
Point of Service	9	169,113	\$279,788,619	19.91%	88.13	\$142
Fee for Service	55	93,385	\$141,905,385	10.10%	79.50	\$149
Other	9	695	\$520,806	0.04%	44.49	\$90
Total	76	822,265	\$1,405,078,420	100.00%	84.06	\$149

Data Source: Utah Accident & Health Survey

* Company count column does not add up to total because an insurer may have more than one plan type.

** Direct earned premium per member per month

Comprehensive Market by Group Size

Comprehensive health insurance plans are sold either as an individual, a group, or a conversion policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees. Groups with 2 to 50 members are classified as small group. Groups with 51 or more members are classified as large group. Conversion policies are sold to individuals whose eligibility for a group policy ended and who “converted” their group policy membership to an individual policy. Conversion policies are typically classified as individual policies.

Group policies reported higher premium per member per month (\$158) than individual policies (\$100). This is probably due to underwriting practices. In individually underwritten policies, insurers have more ability to set rates based on health criteria. As a result, sicker individuals who would incur higher medical costs would be given policy offers with higher premiums than healthier individuals. However, less expensive policies are more likely to be accepted than expensive ones. So the individual market’s lower premium may reflect the tendency for healthier individuals to get and accept more affordable health insurance coverage.

In contrast, group policies are underwritten without taking individual health status into account. Each group is a mix of healthy and sick individuals, and the larger the group the more equally distributed the mix. Thus, medical claims costs tend to be higher and policyholders are charged higher premiums to pay for these additional costs. However, group premiums tend to be less expensive for sicker individuals compared to what they would pay if they were individually underwritten.

Conversion policies had the highest premium per member per month (\$299). This is due to the fact that conversion policies are often issued to individuals who are ill, who have more expensive medical needs, and who have a critical need to continue coverage even though their group policy is no longer available. Less than one percent of the market was insured by conversion policies (see Table 11).

Table 11. Total Comprehensive Market by Group Size for 2003

Group Size	Company Count*	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM**
Total Individual	56	131,551	\$149,345,894	10.63%	79.78	\$100
Individual	50	129,522	\$142,440,650	10.14%	77.37	\$97
Conversion	16	2,029	\$6,905,244	0.49%	129.44	\$299
Total Group	41	690,714	\$1,255,732,526	89.37%	84.57	\$158
Small Group (2-50)	22	224,872	\$404,331,387	28.78%	79.59	\$153
Large Group (50+)	33	465,842	\$851,401,139	60.59%	86.93	\$160
Total Comprehensive	76	822,265	\$1,405,078,420	100.00%	84.06	\$149

Data Source: Utah Accident & Health Survey

* Company count column does not add up to total because an insurer may have more than one plan type.

** Direct earned premium per member per month

Comprehensive Market Trends

This section reports on four significant trends in Utah's comprehensive health insurance market: the number of insurers, the cost of insurance, the number of insured members, and the financial status of the market. Each measure represents a different aspect of the market's "health".

Trends in the number of insurers. The Utah Insurance Department continues to monitor the number of commercial health insurance companies that are providing comprehensive health insurance. The department has data regarding the number of comprehensive health insurers from 1999 to 2003.

Based on this data, the Insurance Department has found evidence of a decline in the number of commercial health insurance companies. In 1999 there were 123 commercial health insurance companies who reported comprehensive health insurance business during the year. As of 2003, only 76 companies were reporting comprehensive health insurance business during the year. Although the numbers may appear significant, this decline is not affecting the competitiveness of the health insurance market.

Under current market conditions, the typical health insurer needs to be large enough to be able to drive membership volume to providers in order to remain competitive. While there is no absolute rule for how large an insurer needs to be, an insurer with a large number of members has more leverage in contract negotiations with providers. This arrangement can benefit both consumers and providers. Consumers may benefit from lower prices and providers may benefit from a higher volume of clients. Many small health insurers cannot "drive volume" as effectively as a large insurer.

Most of the decline in the number of comprehensive health insurers has occurred primarily among smaller health insurers, particularly foreign (non-domiciled) insurers with less than 1 million dollars in comprehensive health insurance premium (see Table 12). In many cases, these small foreign health insurers are providing coverage for "non-situated" policies, that is, commercial health insurance policies that are not filed in the state of residence of the employee. These are often policies issued in another state to an employer with less than 25 percent of their employees living in the state of Utah. The premium is reported as covering a Utah resident, but the policy itself was not sold in Utah or filed with the Utah Insurance Department. Many of these companies are not actively selling health insurance in the Utah health insurance market and are only here because an employee of the company they sold health insurance to is currently a resident in the state. As a result, many of these insurers leave the market when the employees leave the company or the company leaves Utah. Thus, many of these smaller foreign health insurers are covering a special class of Utah residents and may not be really competing directly in the mainstream Utah health insurance market. The decline, therefore, may be due to factors that are more external to the market and is probably not affecting the market very much (see also Table 20 for a list of the relative market shares of Utah's comprehensive health insurers).

In contrast, there has been little change in the number of large domestic health insurers that represent the core of the comprehensive health insurance market (see Table 12). These large health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and competition for Utah's comprehensive health insurance market.

Table 12. Changes in the Number of Comprehensive Insurers: 1999 - 2003

Comprehensive Insurer Category	1999	2000	2001	2002	2003	Net Change
Domestic Insurers						
Greater than 100 Million	4	4	4	4	3	-1
Between 100 Million and 10 Million	5	4	5	3	4	-1
Between 10 Million and 1 Million	6	6	4	3	2	-4
Less than 1 Million	3	3	1	2	1	-2
Total Domestic	18	17	14	12	10	-8
Foreign Insurers						
Greater than 100 Million	0	0	0	0	0	0
Between 100 Million and 10 Million	1	2	2	1	1	0
Between 10 Million and 1 Million	16	15	12	12	11	-5
Less than 1 Million	88	83	75	64	54	-34
Total Foreign	105	100	89	77	66	-39
All Insurers						
Greater than 100 Million	4	4	4	4	3	-1
Between 100 Million and 10 Million	6	6	7	4	5	-1
Between 10 Million and 1 Million	22	21	16	15	13	-9
Less than 1 Million	91	86	76	66	55	-36
Total Utah	123	117	103	89	76	-47

Data Source: Utah Accident & Health Survey

Trends in the cost of insurance. Insurance premiums have increased steadily since 1999. For example, Utah's comprehensive health insurers reported premiums per member per month for 2003 that were 12.0 percent higher than in 2002. This is the largest annual increase during the last five years. However, compared to national employer data, Utah's rate of insurance premium increase appears to be following the national trend (see Table 13). This suggests that Utah's health insurance market is experiencing similar cost pressures as other parts of the country.

Table 13. Comprehensive Premium Compared to National Economic Trends: 1999 – 2003

Year	Comprehensive Premium in Utah				National Economic Trends (Annual Percent Change)		
	Total Premium ^a	Premium PMPM ^b	Premium PMPY ^c	Annual Percent Change	Health Insurance Premium ^d	Overall Inflation	Workers' Earnings
1999	\$1,161,373,601	\$101	\$1,212	N/A	5.3%	2.3%	3.5%
2000	\$1,239,046,717	\$111	\$1,332	9.9%	8.2%	3.1%	3.7%
2001	\$1,311,404,287	\$123	\$1,476	10.8%	10.9%	3.3%	4.1%
2002	\$1,328,724,448	\$133	\$1,596	8.1%	12.9%	1.6%	3.2%
2003	\$1,405,078,420	\$149	\$1,788	12.0%	13.9%	2.2%	3.1%

Data Sources: Utah Premium data are from the Utah Accident & Health Survey from 1999 to 2003. The national trend data used as a comparison comes from the Kaiser/HRET Employer Health Benefits Survey report for 2003.

^a Total direct earned premium

^b Direct earned premium per member per month

^c Direct earned premium per member per year

^d "Health Insurance Premium" trends are based on premium changes for a family of four.

One of the main causes of the trend towards higher premiums is a steady increase in the underlying cost of health care. Utah's health care costs, like the United States as a whole, have increased at a significant rate. For example, comprehensive losses per member per month increased by 13.6 percent from 2002 to 2003 (see Table 14). Nationally, these costs are being driven by a number of factors, particularly increases in pharmacy and hospital costs (Strunk, Ginsburg, & Gabel, 2002; Strunk and Ginsburg, 2003; Strunk and Ginsburg, 2004). Government mandates, increased consumer demand, and litigation, also appear to be important factors (PriceWaterhouseCoopers, 2002).

The rising cost of health care creates significant economic pressure on comprehensive insurers. For example, if Utah's comprehensive insurers had kept premiums at 1999 levels and costs had continued to increase, by 2003, the industry's loss ratio would be approximately 123.76. In other words, the industry would be paying out nearly \$1.24 in claims for every \$1.00 in premium. No business can afford to lose money at such rates for long, so comprehensive insurers responded by raising premium to levels that would cover their costs.

In addition to claim costs, comprehensive insurers also have to pay general administrative costs such as general business expenses and the cost of processing claims. Furthermore, commercial health insurers are also required by state law to maintain adequate financial reserves and to remain financially solvent. This is because health insurers are selling "a promise to pay in the future". When a consumer purchases a health insurance contract, they are buying a promise to pay for future health care costs under certain conditions. Insurers cannot pay claims on behalf of consumers without adequate funds to do so.

Table 14. Comprehensive Losses Compared to National Health Care Spending: 1999 - 2003

Year	Comprehensive Losses in Utah				National Health Care Spending (Annual Percent Change)				
	Loss Ratio ^a	Losses PMPM ^b	Losses PMPY ^c	Annual Percent Change	All	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drugs
1999	89.49	\$91	\$1,092	N/A	7.1%	1.6%	10.2%	5.0%	18.4%
2000	84.59	\$94	\$1,128	3.3%	7.8%	4.1%	9.8%	6.3%	14.5%
2001	84.87	\$104	\$1,248	10.6%	10.0%	8.7%	14.6%	6.7%	13.8%
2002	82.91	\$110	\$1,320	5.8%	9.5%	8.4%	12.9%	6.5%	13.2%
2003	84.06	\$125	\$1,500	13.6%	7.4%	6.4%	11.0%	5.1%	9.1%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 1999 to 2003. The national health care spending data are from the Milliman USA Health Cost Index (\$0 deductible) as reported by Strunk and Ginsburg (2004).

^a Ratio of direct incurred losses to direct earned premium

^b Direct incurred losses per member per month

^c Direct incurred losses per member per year

Although Utah has continued to experience significant increases in the cost of comprehensive health insurance coverage, Utah's premiums appear to be lower than the national average (see Table 15). For example, during 2003, Utah comprehensive health insurers charged approximately \$149 per member per month. In contrast, the Kaiser Employer Benefits Survey (Kaiser/HRET, 2004) reported that the average monthly premium for single coverage among U.S. employers was \$282. Although this comparison does not control for differences in benefits, it is significantly more than Utah's average premium. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

Table 15. Comparison of Utah Premium to National Averages: 1999 to 2003

Year	Utah Estimate				National Estimate ^c			
	Premium PMPM ^a	Premium PMPM % Change	Estimated Family Premium ^b	Family Premium % Change	Premium for Single Coverage	Single Coverage % Change	Premium for Family Coverage	Family Coverage % Change
1999	\$101	-	\$316	-	\$189	-	\$478	-
2000	\$111	9.9%	\$347	9.9%	\$202	6.9%	\$529	10.7%
2001	\$123	10.8%	\$385	10.8%	\$221	9.4%	\$588	11.2%
2002	\$133	8.1%	\$416	8.1%	\$255	15.4%	\$663	12.8%
2003	\$149	12.0%	\$466	12.0%	\$282	10.6%	\$765	15.4%

Data Sources: Utah estimate is based on data from the Utah Accident & Health Survey from 1999 to 2003. National estimate is based on data presented in the Kaiser/HRET Employer Benefits Survey report for the years 1999 to 2003.

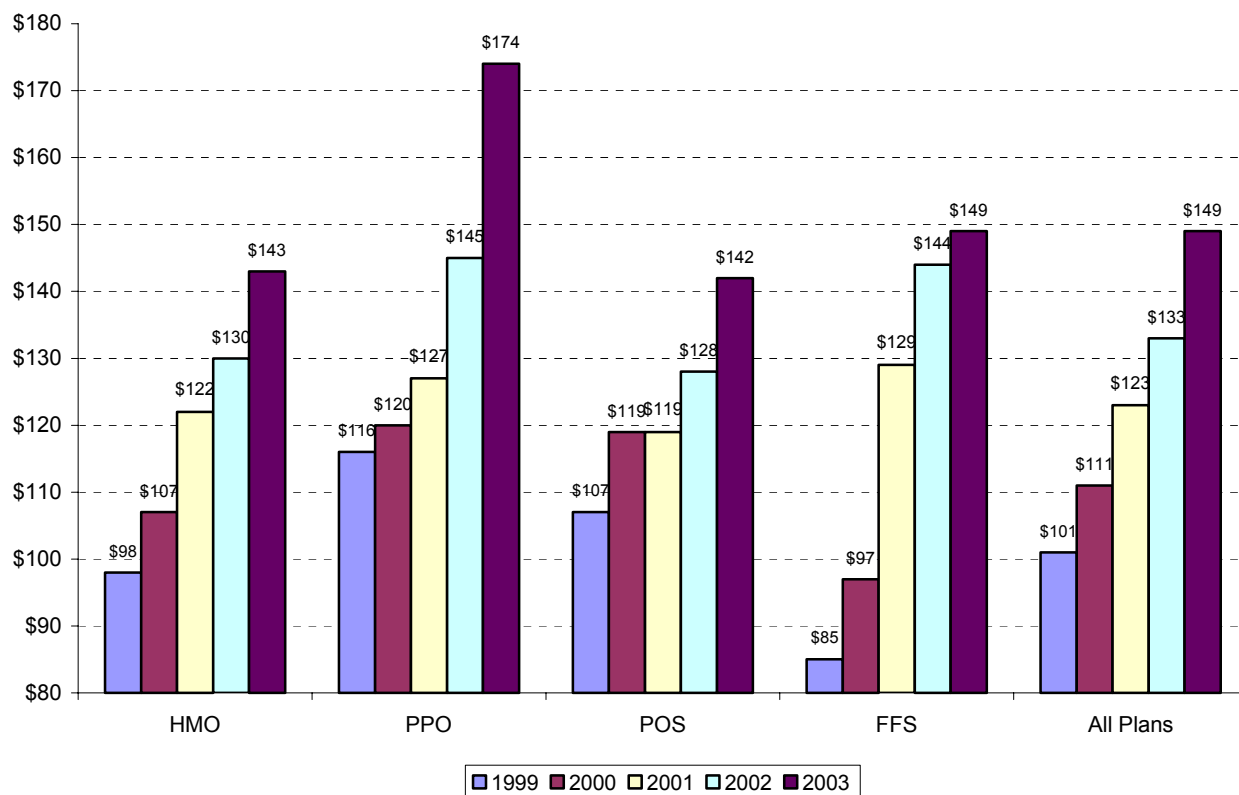
^a Premium per member per month is the average premium per person per month for comprehensive health insurance. This is the estimated cost of health insurance in Utah for all types of hospital and medical coverage and is an average of both single and family rates. A division into single and family rates was not possible using data from the Utah Accident & Health Survey, so premium per member per month is being used as a proxy for the cost of single coverage in order to make a reasonable comparison with the national data.

^b Family rate estimates for Utah were not available, so family premium was estimated by multiplying the average premium per member per month for Utah by the average household size in Utah (3.13 persons per household) as reported by the 2000 Census.

^c According to the U.S. Census Bureau, the average household size in the United States from 1999 to 2003 was approximately 2.6 persons per household. The ratio of single coverage premium to family coverage premium for the Kaiser Employer Benefits Survey was approximately 2.6 during from 1999 to 2003.

The recent premium increases have affected all of the different comprehensive health insurance plan types. Over the last five, years, managed care products such as HMO and POS plans increased less than plans with fewer cost controls such as PPO and FFS. The largest recent increase has been among PPO plans. However, it has been increases among HMO and POS plans that have had the most impact on premium trends in the market (see Figure 2).

Figure 2. Comprehensive Premium PMPM by Plan Type from 1999 to 2003

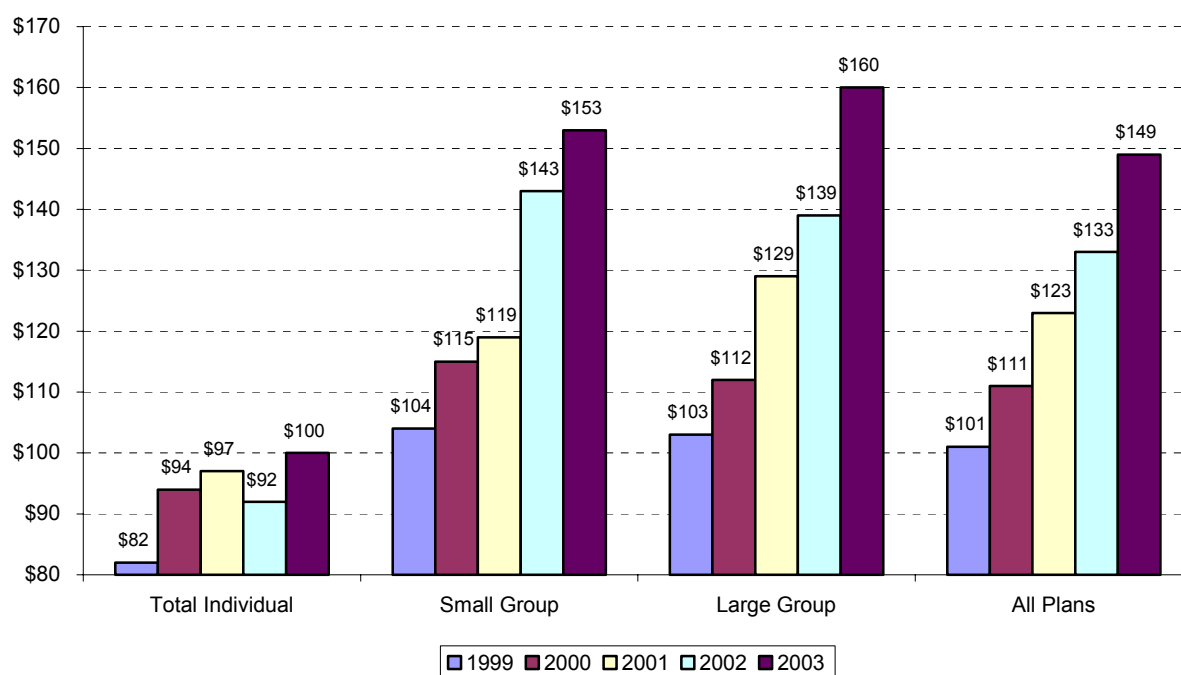


Data Source: Utah Accident & Health Survey

Premium increases have been fairly uniform among different group sizes. Significant premium increases occurred in both large and small group plans. In contrast, individual plans have experienced slightly lower increases (see Figure 3). As mentioned previously, this is probably due to differences in underwriting (see “Comprehensive Market by Group Size” for further discussion).

The changes in large group plans have had the most impact on the premium trends in the market over the last five years. This is primarily because, at least in the comprehensive health insurance market, more Utah residents are covered by large group plans than by any other type. So any changes in this category have a larger impact on market averages than changes in the individual or small group markets.

Figure 3. Comprehensive Premium PMPM by Group Size from 1999 to 2003



Data Source: Utah Accident & Health Survey

For Utah employers and consumers, this trend means that health care is getting more expensive. For a single individual, the average premium per member per year increased from \$1,212 in 1999 to \$1,788 in 2003. This is an increase of 47.5 percent over the last five years. Both consumers and employers are being impacted by this increase. In most cases, employers pay a significant portion of this premium. Nationally, employers pay more than two-thirds of the premium cost (Kaiser/HRET, 2004). However, many employers are responding to the rising cost of health care by increasing the employee's portion of the premium, reducing benefits, or looking at new plan designs such as defined benefit plans. These changes may be difficult for some consumers to accept because the rate of increase in consumer income has not kept pace with the rate of increase in premiums (see Table 16).

Table 16. Changes in Comprehensive Premium and Per Capita Income: 1999 - 2003

	1999	2000	2001	2002	2003
Premium PMPY*	\$1,212	\$1,332	\$1,476	\$1,596	\$1,788
Annual percent change in Premium	-	9.9%	10.8%	8.1%	12.0%
Per Capita Income in Utah	\$22,202	\$23,476	\$24,033	\$24,157(p)	24,330(f)
Annual percent change in Income	-	5.4%	2.7%	0.5%	0.7%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the Economic Report to the Governor (2004).

* Direct earned premium per member per year

p "Projected"

f "Forecasted"

Trends in the number of members. Since 1999, the percentage of Utah residents insured by comprehensive health insurance has declined by 6 percent. During this same period Utah's population has increased by 11.5 percent.

As shown in Table 17, from 1999 to 2003, the individual and small group markets have steadily increased, while the conversion and large group markets have declined. The largest change occurred in the large group market, which declined by nearly 9 percent. Most of these changes occurred between 1999 and 2002. During 2003, the decline in membership stopped and increased slightly from 2002 (see Table 17).

Table 17. Changes in Comprehensive Membership by Group Size: 1999 – 2003

Group Size	1999	2000	2001	2002	2003	Change^a
Individual	96,455	99,034	110,295	126,662	129,522	33,067
As percent of population ^b	4.51%	4.41%	4.80%	5.42%	5.43%	1.55%
Conversion	3,272	2,949	2,139	2,059	2,029	-1,243
As percent of population	0.15%	0.13%	0.09%	0.09%	0.09%	-0.06%
Total Individual	99,727	101,983	112,434	128,721	131,551	31,824
As percent of population	4.66%	4.54%	4.90%	5.50%	5.51%	1.49%
Small Group	200,377	208,561	208,100	237,050	224,872	24,495
As percent of population	9.37%	9.28%	9.06%	10.14%	9.43%	1.15%
Large Group	655,112	624,524	534,484	447,623	465,842	-189,270
As percent of population	30.63%	27.80%	23.28%	19.14%	19.53%	-8.85%
Total Group	855,489	833,085	742,584	684,673	690,714	-164,775
As percent of population	39.99%	37.08%	32.34%	29.28%	28.96%	-7.70%
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	-132,951
As percent of population	44.66%	41.62%	37.24%	34.78%	34.47%	-6.22%
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	246,344
As percent of population	100.00%	100.00%	100.00%	100.00%	100.00%	11.52%

Data Sources: Utah Accident & Health Survey and Utah Population Estimates Committee

^a "Change" measures the change in membership from 1999 to 2003 as a percent of Utah's total population in 1999.

^b "As percent of population" measures the relative percentage of Utah's total population in each particular year.

The reasons for this general decline in membership are complex. Various market forces are in operation. To begin with, the decline in the number of comprehensive health insurers could have contributed to the decline (see Table 12), but this is unlikely. It more likely that the recent increases in the cost of health care and insurance premiums may have led some policyholders to seek less expensive kinds of coverage and this may show up as restructuring in the market place (i.e., shifting membership). Some of this restructuring is evident among the different plan types in the market (see Table 18) and can be observed somewhat in the available data.

First, there has been a steady increase in the number of residents with individual plans. This is largely due to an increase in individual HMO policies in two large managed care insurers. Premiums for individual policies have remained low compared to other options in the market. This may be a significant incentive to switch from more costly types of coverage. However, these lower rates are really only available to those with good health, because individual policies have stricter underwriting requirements than group plans.

Second, there has been a significant decline in the number of residents with individual conversion policies. This is primarily due to declines in conversion POS policies in two large managed care insurers. Conversion policies tend to have a limited duration because they are the result of a person in a group policy who “converts” their group plan into an individual conversion policy. They are intended to act as a temporary bridge between employer group coverage and some other kind of coverage. As a result, one would not expect the number of conversion policies to become very large in the market.

Table 18. Changes in Comprehensive Membership by Plan Type: 1999 – 2003

Plan Type	1999	2000	2001	2002	2003	Change^a
Health Maintenance Organization	517,583	481,995	431,560	404,460	416,952	-100,631
As percent of population ^b	24.20%	21.45%	18.80%	17.29%	17.48%	-4.70%
Preferred Provider Organization	145,481	156,951	159,681	186,208	142,120	-3,361
As percent of population	6.80%	6.99%	6.95%	7.96%	5.96%	-0.16%
Point of Service	187,527	186,536	202,911	163,352	169,113	-18,414
As percent of population	8.77%	8.30%	8.84%	6.98%	7.09%	-0.86%
Fee for Service	84,600	89,756	58,075	55,465	93,385	8,785
As percent of population	3.96%	4.00%	2.53%	2.37%	3.91%	0.41%
Other	20,025	19,830	2,791	3,909	695	-19,330
As percent of population	0.94%	0.88%	0.12%	0.17%	0.03%	-0.90%
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	-132,951
As percent of population	44.66%	41.62%	37.24%	34.78%	34.47%	-6.22%
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	246,344
As percent of population	100.00%	100.00%	100.00%	100.00%	100.00%	11.52%

Data Sources: Utah Accident & Survey and Utah Population Estimates Committee

^a “Change” measures the change in membership from 1999 to 2002 as a percent of Utah’s total population in 1999.

^b “As percent of population” measures the relative percentage of Utah’s total population in each particular year.

Third, the largest change in the market over this period has been a significant decrease in the number of residents within large group policies. This is largely explained by declines in HMO membership (see Table 18) within four managed care insurers. Large group plans are typically sold to large employers. Large employers are the most likely to provide health insurance benefits to their employees and the most likely to provide these benefits through a self-funded health benefit plan. So a decline in this sector could be due to a shift from commercial

health insurance to employer sponsored self-funded health benefit plans, rather than an increase in the uninsured or in government sponsored-health benefit plans. This is difficult to confirm with the available data, but when the four insurers most effected were asked, some were able to confirm that a shift from commercial to self-funded had occurred, while others did not provide a specific reason for the change other than their clients had non-renewed their contracts and that this was simply restructuring in the market.

Additional support for a shift by large employers from the commercial health insurance market to employer sponsored self-funded health benefit plans can be found in the available data on the uninsured and government sponsored health benefit plans. A review of the available data suggests that there has not been large increases in either the uninsured or government sponsored health benefit plans during this period. For example, recent surveys of the uninsured by the U.S. Census Bureau (Mills, 2002; Mills, 2003; DeNavas-Walt, Proctor, & Mills, 2004), the Utah Department of Health (Office of Public Health Assessment, 2004; Office of Public Health Assessment, 2002; Office of Public Health Assessment, 2001), and Utah's commercial health insurance industry (Utah Health Insurance Association/Utah Association of Health Underwriters, 2001) suggest that Utah's uninsured rate has remained fairly constant between 1999 and 2003. Most of the surveys report an uninsured rate of about 9 percent. Federal surveys report a higher rate (between 13 and 14 percent), but report minimal changes in the uninsured during this period.

The available data on Utah's government sponsored health benefit plans does show a moderate increase (see Table 19), but this increase can only account for a small portion of the decline in the commercial market and may simply be due to population increases. Most of the increases are in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Table 19. Changes in Government Sponsored Health Benefit Plans: 1999 - 2003

Plan Type	1999	2000	2001	2002	2003	Change^a
Medicare	201,217	206,056	210,169	214,507	220,221	19,004
Medicaid	132,397	132,569	139,426	154,784	156,031	23,634
Children's Health Insurance Program (CHIP)	10,500	17,391	24,448	24,505	23,761	13,634
Utah Health Assistance Program (UMAP)	3,623	3,615	3,346	4,447	-	-3,623
Primary Care Network (PCN)	-	-	-	-	17,228	17,228
Utah Comprehensive Health Insurance Pool (HIPUtah)	994	1,265	1,767	2,347	2,854	1,860
Government Sponsored Health Benefit Plans	348,731	360,896	379,156	400,590	420,095	71,364
As percent of population ^b	16.30%	16.06%	16.51%	17.13%	17.61%	3.34%

Data Sources: Centers for Medicare & Medicaid Services and Utah Department of Health

^a "Change" measures the change in membership from 1999 to 2003 as a percent of Utah's total population in 1999.

^b "As percent of population" measures the relative percentage of Utah's total population in each particular year.

Thus, changes in the uninsured and government sponsored health benefit plans, as well as the individual and small group market do not seem to account for the significant declines in the large group market. Overall, the available data are consistent with a shift by large employers from the commercial health insurance market to employer sponsored self-funded health benefit plans. This would be a reasonable response from large employers seeking to control the rate of health care costs. Self-funding can be attractive to large employers due to fewer state mandates and greater control over costs due to an increased freedom in health benefit plan design.

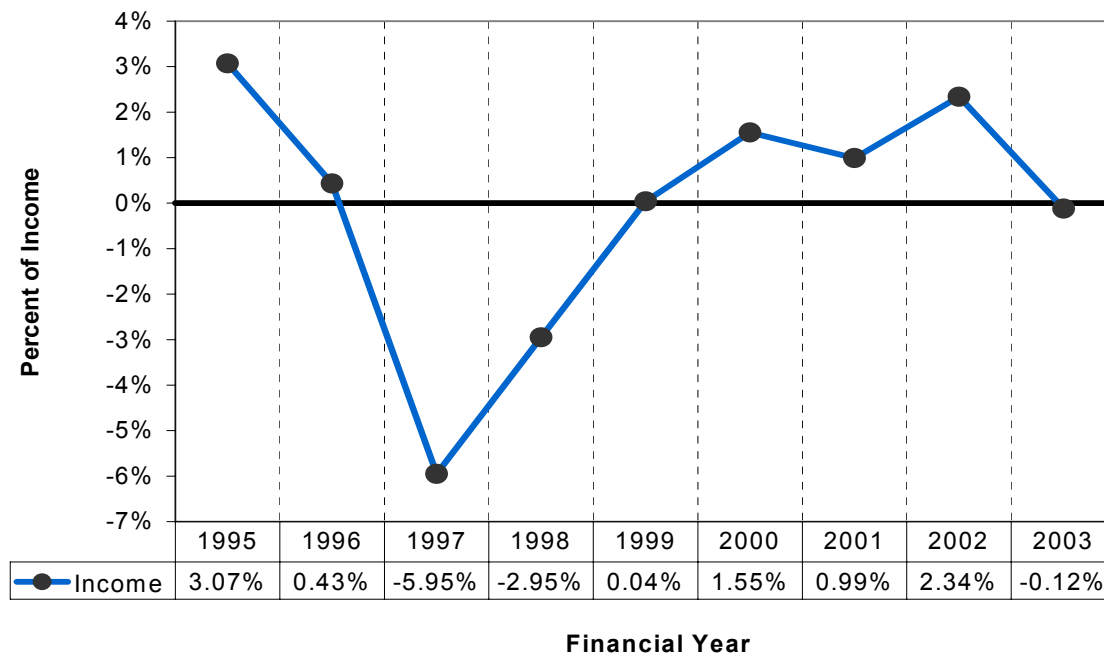
To summarize, the decline in the comprehensive membership from 1999 to 2002 appears to be consistent with a shift from the commercial market to employer sponsored self-funding arrangements, the decline appears to have stopped as of 2003, and there has not been significant increases in the Utah's uninsured during this period of change (e.g. premium increases, population increase, market restructuring, etc.).

Financial trends. To measure the current financial condition of the market, the financial results of the top seven managed care health insurers in Utah were used as an index of Utah's comprehensive health insurance market. These companies were selected because: 1) they represent 89 percent of the 2003 comprehensive health insurance market, 2) they receive more than 75 percent of their revenues from comprehensive health insurance, 3) nearly all of their revenues come from Utah business, and 4) their primary business model is that of a health insurer. Thus, these companies are Utah's best examples of pure comprehensive health insurers and they can provide an index of how well comprehensive health insurers are doing in the Utah market over time.

Health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, to reinvest in new equipment and new markets, and to acquire and maintain needed capital. A knowledgeable investor would expect the net return on investment in a health insurer to equal the return available on high-grade bonds. The results of this index indicate that Utah's comprehensive health insurance market has experienced an average loss of 0.08 percent in net income per year since 1995 (see Figure 4). However, this trend has improved since 1998, with an average of 1.00 percent in net income per year over the last five years, although the market reported a slight loss of 0.12 percent for 2003. This was the first down year since 1998. Thus, despite the recent increases in health insurance premiums, Utah's health insurers are not reporting higher profits. Rather, they appear to be charging enough premium dollars to cover their costs.

Although health insurers are reporting narrow financial margins, all of Utah's core health insurers are financially solvent and have adequate reserves to cover health insurance claims. Utah's health insurers are financially stable and are able to meet their financial obligations to consumers.

Figure 4. Income After Expenses For Managed Care Health Insurers from 1995 to 2003



Data Source: NAIC Financial Database

Note: This figure represents the ratio of net income to total revenue as reported on the NAIC annual statement for the seven largest managed care health insurers that have been operating in Utah since 1995.

Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department.

Approximately 64 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 34 percent of Utah residents. The typical policy in this industry is an employee group policy with a managed care plan administered by a domestic health insurer.

A key function of the Utah Insurance Department is to assist consumers with questions and concerns they may have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the primary agency within the Utah Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the number of consumer complaints received by the Utah Insurance Department has declined every year since 1999. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last five years, there have been four significant trends in the comprehensive health insurance market that the Utah Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined steadily since 1999. This change is mainly due to a decrease in the number of small foreign health insurers participating in the comprehensive health insurance market. In contrast, there has been little or no change in the number of medium to large health insurers. Large domestic health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and competition for Utah's comprehensive health insurance market. This decline has impacted a small portion of the market and Utah's comprehensive health insurance market continues to be competitive.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from \$133 during 2002 to \$149 during 2003, an increase of 12.0 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that health insurers contract to pay for. For example, Utah's health insurers experienced a 13.6 percent increase in losses per member per month from 2002 to 2003. These pricing pressures are not unique to Utah and are being driven by national health care trends that are affecting most states in a similar way. Although these increases are difficult,

Utah's health insurance premiums appear to be lower than the national average. Based on the Kaiser/HRET national survey of employer benefits, the average cost for health insurance coverage for a single person was \$282 per month during 2003. Although this comparison does not control for differences in benefits, this national estimate is significantly more than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

The percentage of Utah residents covered by comprehensive health insurance declined steadily from 1999 to 2002. Based on the available information, this trend appears to be due to a shift by some larger employers from commercial insurance to employer sponsored self-funding arrangements, rather than an increase in the number of people in government programs or the uninsured. Thus, coverage shifted from one type of coverage to another, but there was no significant loss of coverage. As of 2003, this shift appears to have stopped and the number of residents covered by comprehensive health insurance appears to have stabilized. This suggests that consumers, despite rising premiums, are continuing to maintain health insurance coverage with commercial health insurers.

Over the last nine years the top insurers in the comprehensive health insurance industry have experienced an average loss of 0.08 percent. This trend has improved since 1999, however, with the core of the industry experiencing an average gain of 1.00 percent over the last five years. Although premiums have increased significantly during this period, the financial data from Utah's health insurers suggest that they are operating on very conservative financial margins and appear to be only charging enough premiums to cover their costs. Generally, Utah's health insurers are financially stable and are able to meet their financial obligations to Utah consumers.

References

- Council of Economic Advisors (CEA). (2004). Economic Report to the Governor. Salt Lake City, UT: Governor's Office of Economic Planning and Budget.
- Kaiser/HRET. (2004). Employer Health Benefits: 2003 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Educational Trust.
- Mills, R. (2002). Health Insurance Coverage: 2001 (P60-220). Washington, DC: U.S. Census Bureau.
- Mills, R. (2003). Health Insurance Coverage: 2002 (P60-223). Washington, DC: U.S. Census Bureau.
- DeNavas-Walt, C., Proctor, B. D., and Mills, R. (2004). Income, Poverty, and Health Insurance Coverage in the United States: 2003 (P60-226). Washington, DC: U.S. Census Bureau.
- Office of Public Health Assessment. (2001). Overview of the 2001 Utah Health Status Survey (2001 Utah Health Status Survey Report). Salt Lake City, UT: Utah Department of Health.
- Office of Public Health Assessment. (2002). Health Insurance Coverage: Preview Report. Salt Lake City, UT: Utah Department of Health.
- Office of Public Health Assessment. (2004). Utah's Overall Uninsured Rate Shows Little Change Despite Tough Economic Times. Salt Lake City, UT: Utah Department of Health.
- PriceWaterhouseCoopers. (2002). The Factors Fueling Rising Healthcare Costs. Washington, DC: American Association of Health Plans.
- Strunk, B. C., and Ginsburg, P. B. (2003). Tracking health care costs: Trends stabilize but remain high in 2002. Health Affairs, 22 (4), 266-274. Also available at: <http://www.healthaffairs.org/freecontent/v22n4/s6.pdf>
- Strunk, B. C., and Ginsburg, P. B. (2004). Tracking health care costs: Trends turn downward in 2003. Health Affairs, Web exclusive, 9 June 2004. Available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.354/DC1>
- Strunk, B. C., Ginsburg, P. B., and Gabel, J. R. (2002). Tracking health care costs: Growth accelerates again in 2001. Health Affairs, 21 (6), 299-310. Also available at: <http://www.healthaffairs.org/freecontent/v21n6/s3.pdf>
- Utah Health Insurance Association/Utah Association of Health Underwriters. (2001). UHIA/UAHU Survey of the Uninsured. Salt Lake City, UT: Dan Jones & Associates.

Appendix

List of Comprehensive Health Insurers

Table 20. List of Comprehensive Insurers during 2003

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
IHC Health Plans Inc	UT	\$599,859,385	42.69%	88.04
Regence BCBS of UT	UT	\$337,839,452	24.04%	79.02
Altius Health Plans Inc	UT	\$222,425,903	15.83%	83.92
United Healthcare Of UT Inc	UT	\$78,330,429	5.57%	84.76
United Healthcare Ins Co	CT	\$55,819,958	3.97%	83.86
Healthwise	UT	\$26,033,472	1.85%	73.78
Deseret Mut Ins Co	UT	\$15,452,495	1.10%	87.82
Cigna Healthcare Of UT Inc	UT	\$12,211,189	0.87%	90.76
Aetna Life Ins Co	CT	\$8,237,788	0.59%	80.06
IHC Benefit Assur Co Inc	UT	\$7,877,889	0.56%	92.92
Mega Life & Health Ins Co The	OK	\$6,811,803	0.48%	51.25
United WI Life Ins Co	WI	\$5,579,559	0.40%	74.99
Western Mut Ins	UT	\$5,350,401	0.38%	89.23
Mid West Natl Life Ins Co Of TN	TN	\$3,786,994	0.27%	53.36
State Farm Mut Auto Ins Co	IL	\$3,540,292	0.25%	96.89
Connecticut General Life Ins Co	CT	\$2,263,333	0.16%	61.43
Benchmark Ins Co	KS	\$2,130,894	0.15%	12.21
Pacific Life & Annuity Co	AZ	\$2,106,599	0.15%	59.25
Fortis Ins Co	WI	\$1,528,241	0.11%	65.60
Unicare Life & Health Ins Co	DE	\$1,169,992	0.08%	48.64
American Natl Life Ins Co Of TX	TX	\$1,065,950	0.08%	44.49
New York Life Ins Co	NY	\$989,986	0.07%	107.50
Educators Mut Ins Assoc	UT	\$767,487	0.05%	178.67
New England Life Ins Co	MA	\$595,246	0.04%	23.48
National Health Ins Co	TX	\$496,919	0.04%	46.80
Metropolitan Life Ins Co	NY	\$344,233	0.02%	49.02
American Underwriters Life Ins Co	AZ	\$237,290	0.02%	118.01
Great West Life & Annuity Ins Co	CO	\$233,032	0.02%	73.84
Best Life And Health Ins Co	TX	\$221,165	0.02%	9.40
Golden Rule Ins Co	IL	\$208,136	0.01%	181.77
Mutual Of Omaha Ins Co	NE	\$171,256	0.01%	96.83
American Heritage Life Ins Co	FL	\$156,011	0.01%	47.35
World Ins Co	NE	\$146,074	0.01%	117.35
United Of Omaha Life Ins Co	NE	\$122,929	0.01%	252.02
Fidelity Security Life Ins Co	MO	\$113,734	0.01%	38.04
Fortis Benefits Ins Co	MN	\$106,531	0.01%	46.25
Trustmark Ins Co	IL	\$95,322	0.01%	114.58
Union Labor Life Ins Co	MD	\$85,883	0.01%	48.34
John Alden Life Ins Co	WI	\$81,995	0.01%	34.35
Prudential Ins Co Of Amer	NJ	\$75,095	0.01%	52.97
Equitable Life Assr Soc Of The US	NY	\$38,563	< 0.01%	582.67
American Republic Ins Co	IA	\$35,386	< 0.01%	44.50
Principal Life Ins Co	IA	\$34,948	< 0.01%	70.49
Conseco Ins Co	IL	\$34,814	< 0.01%	27.80
Pyramid Life Ins Co	KS	\$31,321	< 0.01%	4.73
Sears Life Ins Co	TX	\$28,976	< 0.01%	4.24
Life Investors Ins Co Of Amer	IA	\$28,036	< 0.01%	451.51
Allstate Life Ins Co	IL	\$19,593	< 0.01%	9.46
Safeco Life Ins Co	WA	\$17,931	< 0.01%	384.12
Continental General Ins Co	NE	\$17,083	< 0.01%	480.92
Chesapeake Life Ins Co	OK	\$13,136	< 0.01%	25.66
Guardian Life Ins Co Of Amer	NY	\$12,584	< 0.01%	122.17

Celtic Ins Co	IL	\$12,538	< 0.01%	595.80
Republic American Life Ins Co	TX	\$11,928	< 0.01%	179.99
Columbia Universal Life Ins Co	TX	\$11,623	< 0.01%	232.76
American States Ins Co	IN	\$10,571	< 0.01%	1672.87
American Natl Ins Co	TX	\$9,329	< 0.01%	-2208.50
Thrivent Financial For Lutherans	WI	\$8,283	< 0.01%	42.40
Federal Home Life Ins Co	VA	\$6,164	< 0.01%	61.89
Central United Life Ins Co	TX	\$6,049	< 0.01%	29.38
New Era Life Ins Co	TX	\$4,945	< 0.01%	0.00
Allianz Life Ins Co Of North Amer	MN	\$3,567	< 0.01%	25.04
United Heritage Life Ins Co	ID	\$3,057	< 0.01%	0.00
Reserve Natl Ins Co	OK	\$1,612	< 0.01%	-78.66
Guarantee Trust Life Ins Co	IL	\$1,457	< 0.01%	-29.10
Oxford Life Ins Co	AZ	\$804	< 0.01%	27.11
Conseco Life Ins Co	IN	\$739	< 0.01%	381.06
Humana Ins Co	WI	\$649	< 0.01%	36.21
Security Financial Life Ins Co	NE	\$614	< 0.01%	207.17
Mony Life Ins Co	NY	\$567	< 0.01%	0.00
Alta Health & Life Ins Co	IN	\$361	< 0.01%	79.50
Physicians Mut Ins Co	NE	\$242	< 0.01%	0.00
National Benefit Life Ins Co	NY	\$177	< 0.01%	0.00
Illinois Mut Life Ins Co	IL	\$161	< 0.01%	0.00
Centre Life Ins Co	MA	\$159	< 0.01%	0.00
Nationwide Life Ins Co	OH	\$111	< 0.01%	-5971.17
All Comprehensive Insurers	76	\$1,405,078,420	100.00%	84.06

Data Source: Utah Accident & Health Survey

List of Health Insurance Mandates in Utah

Coverage mandates

Required by Federal statute:

1. Preexisting conditions (31A-22-605; NAIC Standard)
2. Dependent coverage from the moment of birth or adoption (31A-22-610)
3. Coverage through a noncustodial parent (31A-22-610.5; Social Security Act)
4. Open enrollment for child coverage ordered by a court (31A-22-610.5; Social Security Act)
5. Medicare supplemental insurance, including preexisting conditions provision (31A-22-620; NAIC Standard; Title XVIII of the Social Security Amendment, 1965)
6. Individual and small group guaranteed renewability (31A-30-107; Health Insurance Portability and Accountability Act, 1997)
7. Individual and small group limit on exclusions and preexisting conditions (31A-30-107; Preexisting conditions are required by Federal Statute)
8. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997)
9. Maternity coverage on groups of 15 or more employees (Pregnancy Discrimination Act, Public Law 95-555, 1978)
10. COBRA benefits for employees of employer with 20 or more employees (Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, 1985)

Required by State statute:

1. Policy provision standards (31A-22-605)
2. Dependent coverage to age 26 (31A-22-610.5)
3. Extension of policy for a dependent child with a disability (31A-22-611)
4. Conversion privileges for an insured former spouse (31A-22-612)
5. Mini-COBRA benefits for employees of employer with less than 20 employees (31A-22-722; State expansion of Federal COBRA requirements).

Benefit mandates

Required by Federal statute:

1. Maternity stay minimum limits (31A-22-610.2; Newborn & Mothers Health Protection Act, Public Law 105-35, 1997)
2. Pediatric vaccines – level of benefit (31A-22-610.5, Omnibus Budget Reconciliation Act, 1993)
3. Preauthorization of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act)
4. OB/GYN as primary care physician (31A-22-624)

5. Mastectomy provisions (31A-22-630; Women's Health & Cancer Rights Act, 1996)

Required by State statute:

1. \$4,000 minimum adoption indemnity benefit (31A-22-610.1)
2. Dietary products for inborn metabolic errors (31A-22-623)
3. Catastrophic coverage of mental health conditions (31A-22-625; Required by Federal statute, but State statute is more protective than Federal requirements)
4. Diabetes coverage (31A-22-626)
5. Standing referral to a specialist (31A-22-628)
6. Basic Health Care Plan in individual market (31A-22-613.5 and 31A-30-109)

Provider mandates

Required by Federal statute:

None

Required by State statute:

1. Preferred provider contract provisions, including 75 percent reimbursement provision for non-preferred providers, quality assurance program, nondiscrimination, and grievance process (31A-22-617)
2. HMO payments to noncontracting providers in rural areas (31A-8-501)

Statutory Requirements and Methods Overview

Statutory Requirements

Utah Code Annotated (U.C.A.) § 31A-2-201(7) requires that the Utah Insurance Department produce an annual evaluation of the health insurance market. The statutory requirements for this evaluation are shown below:

- (7) (a) Each year, the commissioner shall:
- (i) conduct an evaluation of the state's health insurance market;
 - (ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and
 - (iii) publish the findings of the evaluation of the department website.
- (b) The evaluation shall:
- (i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as the availability and marketing of individual and group products, rate charges, coverage and demographic changes, benefit trends, market share changes, and accessibility;
 - (ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;
 - (iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and
 - (iv) include claims loss ratio data for each insurance company doing business in the state.
- (c) When preparing the evaluation required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

Methods Overview

This report primarily uses data from two sources: the NAIC Financial Database and the Utah Accident & Health Survey. It also uses information from national data sources and government agencies. The report will continue to evolve as required to meet the needs of the Utah Legislature.

NAIC Financial Database. The NAIC Financial Database is a nationwide database maintained by the National Association of Insurance Commissioners. It contains data obtained from insurance companies' annual financial statements. Data was obtained for companies writing commercial health insurance in Utah during 1999, 2000, 2001, 2002, and 2003. The data summarizes the total accident & health premium and losses in Utah reported by commercial health insurers to the NAIC. It does not provide information on a particular type of health insurance.

Utah Accident & Health Survey. The Utah Accident & Health Survey is submitted annually to the Utah Insurance Department. All commercial health insurers are required to file

this report. This survey provides detailed information on commercial insurance activity in Utah. It includes information that allows the Insurance Department to estimate trends in Utah's commercial health insurance market, including market share, number of covered lives, loss ratios, and cost of insurance. Data is available for 1999, 2000, 2001, 2002, and 2003. The data includes information on approximately 400 companies each year.

The survey is divided into four parts: accident & health insurance, long term care & Medicare supplement insurance, comprehensive health insurance, and administration of self-funded plans. The accident & health insurance portion of the survey must balance to the total accident & health insurance business reported on the Utah business section of the annual statement. The comprehensive insurance section includes detailed information on plan types, group size, and year-end member months. This additional detail allows the Insurance Department to evaluate changes in the comprehensive health insurance market with much greater accuracy.

The Utah Accident & Health Survey is limited in its ability to track changes in benefit structures, so research using the survey cannot control for differences in specific benefits. Despite this limitation, this survey (along with the NAIC Financial Database) is the primary source of data on Utah's commercial health insurance market and as such provides valuable information on commercial health insurance.